DHSR – 4/23/08-4/25/08
John Umstead Hospital (JUH)
Plan of Correction

Corrective Actions	Complete Date
A 404 482.23(c) ADMINISTRATION OF DRUGS: Drugs and biologicals must be prepared and administered in accordance with Federal and State laws, the orders of the practitioner or practitioners responsible for the patient's care as specified under 482.12(c) and accepted standard of practice.	
Based on open medical records review and staff interview the nursing staff failed to administer medication per the physician's order in 1 of 5 open records reviewed.	
The Adult Admissions Unit (AAU) Clinical Nurse Specialist (CNS) identified this complex medication error and completed a medication error report. The error was investigated and it was determined that the error was caused by verification (confirmation) problems by Pharmacy staff with the initial entry of the order in the automated medication system and compounded when nursing staff failed to perform verification of the orders during 3rd shift checks. The error was also attributed to a physician order that was not clearly written on the Preadmission Medication List/and Physician Order form.	4/22/08
Nursing Staff The Associate Director of Nursing (ADON) issued a memo to AAU RN staff stating the expectation that 3rd shift RNs must check each medication order written in the last 24 hours against the electronic MAR for each patient on the ward to ensure that the orders have been entered and confirmed (verified) correctly.	4/25/08
Monitoring: The ADON developed a 3rd shift re-verification of orders audit tool that will be used by 3rd Shift Supervisors to review/ensure that 3rd shift RN staff are performing confirmation of medication orders that have been written within in the previous 24 hours. The audit results are submitted to the Adult Admissions Unit Nurse Director on a weekly basis.	4/30/08
Pharmacy Staff The Pharmacy Director added an additional confirmation (verification) check of all medication orders that are entered into the automated medication system. There are now 4 verification checks performed by pharmacy staff - a Pharmacist confirms the physician hand written order when he/she enters it into the computer, the 2 pharmacy technicians check the order against the medication label generated by the computer and finally another pharmacist confirms the order again before it is activated in the automated medication system.	4/25/08
Monitoring: The Pharmacy staff will submit any medication orders that were incorrectly entered into the automated medication system and discovered during the verification process to the Pharmacy Director. The Pharmacy Director will review these errors to identify trends and areas for improvement.	4/30/08
Physician Staff The Clinical Director instructed JUH Medical Staff via an email communication that to reduce the likelihood of medication transcription errors, the physician staff should not write more than one order in each box on the Preadmission Medication List/and Physician Order form.	4/25/08
Monitoring: The Clinical Director will conduct audits of Preadmission Medication List/and Physician Orders to determine if the physicians are following the instructions given on 4/25/08 to	5/19/08

only write one order per box on the Preadmission Medication List/and Physician Order form.	
A 500.482.25(b) CONTROL AND DISTRIBUTION OF DRUGS: In order to provide patient safety, drugs and biologicals bust be controlled and distributed in accordance with applicable standards of practice, consistent with Federal and State law.	
Based on medical record review and staff interview the pharmacist failed to transcribe a written physician's order correctly in 1 of 5 open medical records reviewed.	
The Adult Admissions Unit (AAU) Clinical Nurse Specialist (CNS) identified this complex medication error and completed a medication error report. The error was investigated and it was determined that the error was caused by verification (confirmation) problems by Pharmacy staff with the initial entry of the order in the automated medication system and compounded when nursing staff failed to perform verification of the orders during 3rd shift checks. The error was also attributed to a physician order that was not clearly written on the Preadmission Medication List/and Physician Order form.	4/22/08
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Monitoring: The Clinical Director will conduct audits of Preadmission Medication List/and Physician Orders to determine if the physicians are following the instructions given on 4/25/08 to only write one order per box on the Preadmission Medication List/and Physician Order form.	5/19/08